



November 2009

House Releases Health Care Bill

House Democratic leaders unveiled the chamber's final health reform bill (**HR 3962**), which includes a public option favored by moderates that would have providers negotiate their reimbursement rates directly with the government. House Democrats aim to take it to the floor this week, with a final vote before November 11. The Congressional Budget Office (CBO) estimates that the bill would cost \$894 billion, consistent with the \$900 billion coverage mark laid out by President Obama, and would not increase the federal deficit over the next 10 years. The bill includes:

- **Community Health Centers.** Increases funding for CHCs that would allow for a doubling of the number of patients seen by the centers, effective upon enactment.
- **Immediate Help for the Uninsured (Interim High-Risk Pool).** Creates \$5 billion fund, modeled after the President's plan, to finance an immediate, temporary insurance program for those who are uninsurable because of pre-existing conditions.
- **Community preventive services grants.** Establishes new grant program for states to provide prevention and wellness services to communities, with a special emphasis on health disparities.
- **School-Based health clinics.** Establishes a new grants program to support school-based health clinics that provide health services to children and adolescents.
- **Eligibility for Health Insurance Exchange.** People are eligible to enter the Exchange and purchase health insurance on their own as long as they are not enrolled in employer sponsored insurance, Medicare or Medicaid. The Exchange is also open to businesses, starting with small firms and growing over time. Firms with twenty-five or fewer employees are permitted to buy in the Exchange in 2013, firms with fifty or fewer employees in 2014, and firms with at least one hundred employees in 2015 with discretion to the Commissioner to open the Exchange to larger businesses in that year and the future.
- **Ends discrimination for e-existing medical conditions**
- **Prohibits insurance companies from dropping coverage**
- **Has yearly caps on what families will have to pay & eliminates lifetime caps on coverage**



Rosalyn Frazier, Chief Executive Officer, Broward Community & Family Health Center, with Nancy Pelosi

IMPACT ON SECTION 330 & COMMUNITY HEALTH CENTERS

The House bill contains critically important investments in health care access **including \$12 billion in new, guaranteed funding for health centers over the next five years.**

ADDITIONAL annual funding each year is:

- 2011: \$1 billion
- 2012: \$1.5 billion
- 2013: \$2.5 billion
- 2014: \$3.0 billion
- 2015: \$4.0 billion

Current Section 330 funding is approximately \$2 billion per year.

This allows BPHC/HRSA to increase EXPANSION funding, CAPITAL funding, and NEW ACCESS POINTS.

The bill also would expand eligibility for Medicaid in an effort to reduce the legislation's cost. Those who earn less than 150% of the federal

poverty level would be eligible for Medicaid coverage under the bill. Previous versions of the bill had raised the threshold to 133% of the poverty level. Proponents of the eligibility expansion say that it would be cheaper to provide low-income people with insurance coverage under Medicaid than it would be to offer them subsidies for private insurance coverage.

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Health Reform Process, What Health Centers Should Do

It is important to remember that the House bill will certainly be amended as it is debated on the House floor this week. Additionally, through the reconciliation process, the House bill and the eventual Senate bill will be merged.

The Senate has two bills that are currently being “meshed” or merged. The outcome of the merging has not yet been released to the public.

Both Senate bills contain significant increases in Section 330 funding.

Health centers should continue to embark on expansion planning, both in terms of capital needs and services. With such profound increased funding, HRSA/BPHC will be stretched to spend these funds even more than we have witnessed with stimulus funding.

Strategies to consider include

expanding scope of services, submitting change of scope to include sites and/or services not currently in your 330 scope, collaboration with safety net hospitals to position yourselves for Collaborative Care Network funding AND continue to work towards meeting the “meaningful use” criteria for information technology.

SGA is available to assist with your strategic planning and feasibility studies.



Additional House Bill Impacts on Health Centers

The House bill also includes funding for:

The establishment of **Primary Care Training Programs** including a demonstration project to establish **Teaching Health Centers**.

Establishes **Federally Qualified Behavioral Health Centers**, no later than 18 months after legislation passes, and requires providing primary care services.

Establishes **Community-Based Collaborative Care Networks**, a consortium of health care providers with a joint governance structure that provides a comprehensive range of coordinated and integrated services for low income populations and/or medically underserved areas. (Note: FQHCs still required to meet 330 governance requirements, as well.) To qualify, a network must include a safety net hospital

and ALL FQHCs in the service area. Optional providers are health departments, RHCs, other hospitals, other providers (mental health, substance abuse, dental, etc.)

Establishes **Independent Patient Centered Medical Homes**.

Allows volunteer providers to be covered under FTCA.

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Susan Greene

RYAN WHITE EXTENDED FOR 4 YEARS

Last week, both Houses of Congress passed the Ryan White HIV/AIDS Treatment Extension Act of 2009. The Senate passed the bill by unanimous consent on October 20 and the House passed the bill by a vote of 408 to 9 on October 21. The bill will extend

for four years (through September 30, 2013) the Ryan White Program, which provides funding to cities, states and public and nonprofit entities to assist in core medical and support services for people living with HIV/AIDS. The legislation increases authorizations for all parts of the program by

5% for each year through 2013 from \$2.55 billion in FY2010 to \$2.95 billion in FY2013. The legislation will also increase authorizations for the MinorityAIDs Initiative by 5% annually.

President Obama signed the legislation on October 30, 2009.



HOUSE BILL IMPACT ON MEDICAID AT STATE LEVEL

Medicaid. Increases assistance to states that maintain access to Medicaid services during the recession by extending the current Recovery Act Funding increase in federal Medicaid payments to states with high unemployment rates.

Payments for primary care services. Requires that physicians and other practitioners are paid for primary care services they provide to Medicaid patients at 100 percent of Medicare rates beginning in 2012. The federal government will pay 100 percent of the increased costs in 2012 through 2014, 90 percent thereafter.

Managed care organizations. Requires that Medicaid MCOs meet a medical loss ratio standard set by the Secretary of HHS at not less than 85 percent.

Medicaid and CHIP. Expands Medicaid coverage to everyone within income at or below 150 percent FPL (\$33,100 per year for a family of 4) who is not eligible for Medicare. Eliminates assets tests for eligibility groups other than for long-term care. Requires States that now cover

Coverage for HIV-positive individuals. Allows State Medicaid programs to cover low-income individuals who are HIV positive through December 31, 2013, after which coverage will be available through the Health Insurance Exchange or, for those with incomes at or below 150 percent of poverty, Medicaid. States would receive the enhanced federal matching rate for these costs.

Prohibitions on Medicaid and CHIP payment for undocumented immigrants. Provides that the Medicaid title does not change current prohibitions against Federal Medicaid or CHIP payments for persons not lawfully present in the U.S.

those above 150 percent FPL to maintain eligibility. States receive full federal funding for costs of expansion populations in 2013 and 2014. Thereafter, States pay 9 percent and the federal government pays 91 percent. CHIP-eligible children move to the Exchange or Medicaid in 2014.

Medical home pilot program. Establishes a 5-year pilot program to evaluate medical home models for beneficiaries including medically fragile children. A total of \$1.235 billion is made available for increased federal matching for administrative costs. percent.



“THE STATE MEDICAID AGENCIES WILL PAY LESS THAN 10% OF THE COSTS OF INSURING CHILDLESS ADULTS UP TO 150% POVERTY”





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Since 1998, SGA has worked with safety net providers across the county, including public and private hospitals, health systems, FQHCs, free clinics and other providers to assess capacity, conduct FQHC feasibility studies, access federal funding, identify and negotiate strategic partnerships, and conduct operational assessments to expand access to care for the underserved.

Firm activities include:

- Strengthening Ambulatory – Hospital Partnerships
- Building Collaborative Relationships
- Strategic Planning for Health Systems, Community Health Centers, Physicians
- Complex Project Management for public agencies and health systems
- Operational Assessments for long term Sustainability and Capacity Expansion
- Federal FQHC Look-Alike and Section 330 CHC strategy and application(s)
- Strategic Positioning & Business Plan Development
- Community Needs Assessment & Target Population Strategies
- Policy Analysis with particular expertise in Medicaid
- Project Management
- Facilitation of Meetings of Board of Directors, Executive Staff, Managers

IMPACT ON EMPLOYERS (including health centers)

Employer responsibility to contribute toward employee and dependent coverage.

Provides that the minimum employer contribution in the case of an offering employer is 72.5% of the premium for individual coverage, and 65% of the premium for family coverage or a proportional amount for non-fulltime employees. Small employers with annual payrolls at or below \$500,000, are exempt from this requirement. The contribution phases up from 0-8% between an annual payroll of \$500,000 and \$750,00, at which point employers are subject to the full 8% contribution requirement.

Employer contributions in lieu of coverage.

Requires an offering employer to contribute to the Exchange for each employee who declines the employer's coverage offer and enters the Exchange via the affordability test outlined in the act. The contribution is generally 8% of the average salary for the employer.

Authority related to improper steering.

Authorizes the creation of rules that would prohibit employers from engaging in practices that steer employees away from employer-offered coverage and into coverage offered under the Exchange.

Limitation on health flexible spending arrangements under cafeteria plans.

Limits salary reduction contributions to health flexible spending arrangements to \$2,500 (indexed to the consumer price index).

Increase in penalty for non-qualified distributions from health savings accounts.

Increases the 10 percent penalty on distributions from health savings accounts that are not used to pay for health related expenditures to 20 percent.



SARA KANDLER JUST COMPLETED HER FIRST YEAR AS PROJECT ASSOCIATE WITH SGA.